THE NATIONAL QUALITY FORUM

SERIOUS REPORTABLE EVENTS IN HEALTHCARE: 2005-2006 UPDATE

PURPOSE

In 2002, the National Quality Forum (NQF) published a report, *Serious Reportable Events in Healthcare,* which identified 27 adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers. NQF has now formally launched the Consensus Standards Maintenance Committee on Serious Reportable Events to review the list and recommend additions or changes for Members to consider so that the set remains current and appropriate.

BACKGROUND

The objective of the report and project was to establish consensus among consumers, providers, purchasers, researchers, and other healthcare stakeholders about those preventable adverse events that should never occur and to define them in a way that, should they occur, it would be clear what had to be reported. The original use of the list was intended to be as part of a federally funded, national five-state pilot project to bring order to adverse event reporting in the United States. Because the demonstration project was not realized, implementation at the state level was pursued as an alternative, and active outreach by the NQF to states was undertaken.

The original list of events was not intended to capture all events that might possibly be useful to report. Rather, the items on this list are events that are:

- of concern to both the public and healthcare professionals and providers;
- clearly identifiable and measurable, and thus feasible to include in a reporting system; and
- of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility.

SCOPE

Maintenance of the list of events will include:

- review of the NQF-endorsed "never events" for continued currency and appropriateness;
- recommendation of new "never events" for endorsement;
- recommendations related to the need foradditional specifications for the events; and
- recommendations related to enhancing implementation of the list of events at the state and national level.

THE NQF PROCESS

The maintenance process, like all NQF activities, involves the active participation of representatives from across the spectrum of healthcare stakeholders. The project is guided by the Consensus Standards Maintenance Committee, which will evaluate the practices and make recommendations to refresh the currently endorsed set. Agreement around the recommendations will be developed through NQF's formal Consensus Development Process.

FUNDING

Funding to support the maintenance effort will come from the NQF's general operating funds; other sources of funding will be sought.

For more information, contact Melissa Stegun at 202.783.1300 or info@qualityforum.org.

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National Voluntary Consensus Standards Maintenance Committee on Serious Reportable Events

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National Quality Forum List of Adverse Events the Washington State Department of Health is Adopting June 7, 2006

1. **SURGICAL EVENTS**
   a. Surgery performed on the wrong body part
   b. Surgery performed on the wrong patient
   c. Wrong surgical procedure performed on a patient
   d. Retention of a foreign object in a patient after surgery or other procedure
   e. Intraoperative or immediately post-operative death in an ASA Class I patient
2. **PRODUCT OR DEVICE EVENTS**
   a. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
   b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
   c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
3. **PATIENT PROTECTION EVENTS**
   a. Infant discharged to the wrong person
   b. Patient death or serious disability associated with patient disappearance for more than four hours
   c. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
4. **CARE MANAGEMENT EVENTS**
   a. Patient death or serious disability associated with a medication error
   b. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
   c. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
   d. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
   e. Death or serious disability associated with failure to identify and treat hyperbilirubinimia in neonates
   f. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
   g. Patient death or serious disability due to spinal manipulative therapy
5. **ENVIRONMENTAL EVENTS**
   a. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
   b. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
   c. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility

d. Patient death associated with a fall while being cared for in a healthcare facility
e. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

6. CRMIINAL EVENTS

a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
b. Abduction of a patient at any age
c. Sexual assault on a patient within or on the grounds of a healthcare facility
d. Death or significant injury of a patient or staff member resulting from a physical assault